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Note

Restricting Access to Infertility Services: What is a Justified Limitation on Reproductive Freedom?

The Categorical Exclusion of Single Women and Same-Sex Couples from Infertility Services and its Role in Defining What Constitutes Justified and Unjustified Limitations on Reproductive Freedom

*Crystal Liu**

INTRODUCTION

The development of reproductive technologies such as artificial insemination and in vitro fertilization (IVF) has given infertile couples a way to procreate. Given that reproductive technologies involve potential children and parentage, there has been much debate as to if, and how, this realm should be regulated. While the regulation of reproductive technologies can exist in a variety of forms, for the purpose of this note I will focus on the restriction of access to these technologies. More specifically, whether access to infertility services should be limited as a means to restrict the ability for single women and same-sex couples to procreate and rear children.

The United States is a leader in assisted reproductive technologies, but it has been extremely hesitant to provide oversight of these technologies at a federal governmental level.¹ While advisory committees and professional self regulation provide oversight to a certain extent, there is no official body

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1. See DEBORA L. SPAR, THE BABY BUSINESS: HOW MONEY, SCIENCE, AND POLITICS DRIVE THE COMMERCE OF CONCEPTION 5 (2006).

within the United States with adequate enforcement powers to regulate infertility research and services.² In contrast, Australia, also a leader in ART, has provided oversight at both the state and national level.³ More specifically, the state of Victoria became “the first common law jurisdiction in the world” to regulate technologies in this field through legislation.⁴

Given the two plus decades in which Victoria has regulated infertility services, the United States can look to the Victorian experience when reviewing its current system of oversight. The aim of this paper is to recommend appropriate types of access restrictions for the United States by conducting an in depth case study on the history of access requirements in Victoria, Australia.

Part one provides background information about infertility and various types of assisted reproductive technologies. Part one also offers a brief explanation as to the science behind these techniques.

Part two provides a synopsis of historical examples in which reproductive freedoms have been limited and the lessons that can be drawn from them. For purposes of this article, reproductive freedom refers not only to the ability to procreate but to the ability to be a parent as well. First, I will discuss the eugenics movement in the early 1900s, and the forced sterilizations that were utilized as a means to promote the good of society. Second, I will discuss adoption and the factors that are considered when limiting the adoptive placement of children. Third, I will discuss the role of child protective services in ensuring that children are not in situations that pose a risk of harm. In all three of these historical (and current) examples, informal or formal restrictions have been placed on reproductive freedoms.

Part three provides a brief overview of three jurisdictions that have approached the issue of regulating access to

2. See PRESIDENT'S COUNCIL ON BIOETHICS, REPRODUCTION & RESPONSIBILITY: THE REGULATION OF NEW BIOTECHNOLOGIES (2004), at 174-79.

3. See Helen Szoke, *Australia—A Federated Structure of Statutory Regulation of ART*, in THE REGULATION OF ASSISTED REPRODUCTIVE TECHNOLOGY 75-78 (Jennifer Gunning & Helen Szoke eds., 2003), for a discussion of the various types of ART regulation in the Australian states.

4. *Id.* at 75.

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reproductive technologies differently. Part three then focuses on the Victorian access provision and the major events that have occurred throughout the history of this legislative provision.

Part four analyzes the challenges that have been made to the Victorian access requirements and discusses reasons why there have been both successful and unsuccessful challenges to this provision. While only married couples were eligible to access infertility services under the original legislation, this legislation was later challenged and amended to expand access to de facto couples. However, a subsequent challenge yielded little legislative response, and single women and same-sex couples have yet to be accorded full access to infertility services. In comparing the two challenges, I will examine the variation between them and probe whether this differential outcome is warranted. The lessons that can be learned from both the Victorian experience in restricting access to infertility services, and the historical examples of restricting reproductive freedom, lead to the conclusion that it is improper to categorically exclude single women and same-sex couples from infertility services.

I. THE STRUGGLE WITH INFERTILITY

A. INFERTILITY

Infertility is, generally, either a specific medical condition or the inability to conceive over a set period of time.⁵ There are several medical conditions that can cause male and female infertility.⁶ Female infertility can be the result of endometriosis, pelvic inflammatory disease, and polycystic ovary syndrome, as well as many other causes.⁷ Male

5. See EMILY JACKSON, *REGULATING REPRODUCTION: LAW, TECHNOLOGY AND AUTONOMY* 162 (2001) (pointing out that while “[a]n objective definition of infertility is . . . probably impossible,” the definitions typically include failure to conceive over a set time); RACHEL KRANZ, *REPRODUCTIVE RIGHTS AND TECHNOLOGY* 5-6 (2002) (calling infertility a medical malfunction or an inability to get pregnant).

6. KRANZ, *supra* note 5, at 5-6.

7. EhealthMD, *What Causes Infertility*, http://www.ehealthmd.com/library/infertility/INF_causes.html (last visited Oct. 13, 2008). Endometriosis occurs when the uterine lining grows into the vagina, ovaries, fallopian tubes or pelvis, resulting in cysts that may then block the passage of the egg. *Id.* Pelvic inflammatory disease occurs when the pelvis or reproductive organ become infected. *Id.* Polycystic ovary syndrome occurs when the ovaries produce excess male and female hormones, resulting

infertility can be the result of several different factors, for example sperm problems (low sperm count, sperm of a poor mobility) and difficulty with ejaculation.⁸

Despite the many factors that can lead to infertility, an individual's or couple's infertility often cannot be diagnosed as a specific medical condition.⁹ In such instances, infertility is explained not by a medical condition, but defined by the inability to conceive or carry a pregnancy to full term over a set period of time.¹⁰ The World Health Organization defines this period of time as two years, while the standard medical definition is twelve months, or at least three consecutive miscarriages or stillbirths.¹¹ According to data obtained from the 2002 National Survey of Family Growth, twelve percent of women in 2002 experienced infertility.¹² Given that this accounts for over seven million women between the ages of fifteen and forty-four, there is an understandable demand for infertility research and services. It is also important to note that while there is debate as to whether or not same-sex couples and single women are considered infertile, these categories of persons are also unable to conceive given their social circumstances.¹³

B. ASSISTED REPRODUCTIVE TECHNOLOGIES (ART)

The development of a variety of alternative conception methods introduced methods by which couples and individuals suffering from infertility could try to conceive. Intrauterine insemination, either using sperm from the male partner or a donor, involves the insertion of collected sperm into the reproductive tract of the woman.¹⁴ One of the more common ART procedures is *in vitro* fertilization.¹⁵ By using

in the follicles forming fluid-filled cysts rather than producing eggs. *Id.*

8. KRANZ, *supra* note 5, at 6.

9. See JACKSON, *supra* note 5, at 162 (claiming that for some, the medical condition is either temporary or of an unexplained source).

10. *Id.*

11. *Id.*

12. NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH & HUMAN SERVS., SER. 23, NO. 25, FERTILITY, FAMILY PLANNING, AND REPRODUCTIVE HEALTH OF U.S. WOMEN: DATA FROM THE 2002 NATIONAL SURVEY OF FAMILY GROWTH 21–22 (2005).

13. JACKSON, *supra* note 5, at 162.

14. KRANZ, *supra* note 5, at 20.

15. JACKSON, *supra* note 5, at 166.

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hyperstimulatory drugs to stimulate the maturation of ovarian follicles, eggs can be collected using a technique such as laparoscopy.¹⁶ The egg is then fertilized with sperm in an artificially created environment that is conducive to embryo development.¹⁷ Embryos are typically implanted into the woman's uterus between two and five days after the initial fertilization.¹⁸ There are a number of other procedures that can be used to treat infertility—gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and intracytoplasmic sperm injection (ICSI).¹⁹

II. HISTORY OF LIMITATIONS PLACED ON REPRODUCTIVE FREEDOMS

Reproductive freedom, for the purposes of this article, refers to “the freedom to determine when, whether, and under what conditions one will or will not bear children.”²⁰ This freedom extends not only to the conditions surrounding having children, but also to the freedom to rear a child as well. Like other freedoms, reproductive liberty is not absolute and is subject to a variety of restrictions.²¹ Over the past century, restrictions on reproductive freedom have taken several forms.²² By exploring limitations that have been enacted, some of which have been repealed while others remain, it is possible to recognize what constitutes an acceptable limitation.

16. ANDREA L. BONNICKSEN, *IN VITRO FERTILIZATION: BUILDING POLICY FROM LABORATORIES TO LEGISLATURES* 147–48 (1989).

17. KRANZ, *supra* note 5, at 23.

18. *Id.*

19. In GIFT, the egg and sperm are inserted into the women's fallopian tubes such that successful fertilization occurs *in vivo*. *Id.* at 23. In ZIFT, eggs are retrieved and fertilized *in vitro* but are transferred back into the women's fallopian tubes much sooner than the typical 2-5 days in IVF. *Id.* at 23–24. In ICSI, eggs are retrieved and fertilized *in vitro* with a single sperm using a microsurgical needle, and successful fertilization yields a zygote that can be transferred into the women's uterus. *Id.* at 24; *see also* JACKSON, *supra* note 5, at 167–68 (explaining the procedures in GIFT and ICSI, and the situations in which they are used).

20. Rosalind Pollack Petchesky. *Reproduction, Ethics, and Public Policy: The Federal Sterilization Regulations* 9 HASTINGS CENTER REP., Oct. 1979, at 29, 29.

21. *See* JOHN ROBERTSON, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* 22–42 (1994) (describing procreative liberty as a right, and the various constraints that can act upon it).

22. *See* discussion *infra* Part II.

A. EUGENICS AND FORCED STERILIZATIONS

The regulation of reproductive freedom is not a new phenomenon. Old concepts have merely been redefined in the age of reproductive technologies. As early as the 1900s, states passed statutes providing for the forced sterilization of those it deemed unfit.²³ In *Buck v. Bell*, the United State Supreme Court upheld a lower court's decision that a Virginia act that allowed for the sterilization of those who were mentally defective was not unconstitutional.²⁴ Prior to being sterilized, Carrie Buck had been committed to the Virginia Colony for Epileptics and Feebleminded in June 1924, only four years after her mother had been committed.²⁵ Carrie's daughter, Vivian, was deemed below average in intelligence by Arthur Estabrook (a field researcher who worked for the Eugenic Record Office) and "not quite normal" by a nurse.²⁶ The ruling by the Court, in particular Justice Holmes' opinion, underscored a state's ability to limit the reproductive freedom of those it deemed socially inadequate.²⁷

This Virginia act was only one of several programs promoted as part of the eugenics movement in the early 1900s.²⁸ Eugenics was based on the belief that unfit

23. See Frances Oswald, *Eugenical Sterilization in the United States* 36 AM. J. SOC. 65, 67 (1930) (noting that Indiana in particular authorized the sterilization of "confirmed criminals, idiots, imbeciles, and rapists").

24. *Buck v. Bell*, 274 U.S. 200, 200-201 (1927). The Virginia act allowed for the sterilization of those who were considered feeble minded as a means to safeguard the health of the patient and promote the welfare of society. *Id.*

25. Paul A. Lombardo, *Facing Carrie Buck*, 33 HASTINGS CENTER REP., Mar.-Apr. 2003, at 14., 15

26. *Id.* at 16.

27. *Id.* at 14 (noting that Justice "Holmes' opinion became the rallying cry for American eugenicists."); see 274 U.S. at 207 (Holmes, J.) :

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough.

(citation omitted).

28. See generally ANNE KERR & TOM SHAKESPEARE, GENETIC POLITICS: FROM EUGENICS TO GENOME 16 (2002) (discussing the relevance of the eugenics movement in The Johnston-Reed Act of 1924, an immigration policy

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characteristics were inheritable and that the stock of the population could be improved by preventing the transmission of these traits.²⁹ Eugenic programs were viewed as a means to enhance the strength of the nation.³⁰ While the eugenics movement has largely been discredited and Virginia has since issued an official apology renouncing its involvement in the forced sterilization of those deemed ‘unfit’, the limitation of reproductive freedoms has continued, albeit in different forms.³¹

B. Adoption

Adoption is yet another realm in which reproductive freedoms are limited by a complicated set of state, federal, and international laws.³² However, it is at the state level, with a few exceptions, that adoptions are actually authorized.³³ Adoption has important social and legal implications.³⁴ Legally, adoption severs the relationship between a child and his biological family and establishes a relationship between the child and the adoptive parents.³⁵ From a social perspective, the child is being placed with parent(s) who are prepared to assume parental responsibilities because their biological parent(s) are unwilling or unable to do so.³⁶

These adoptive relationships have traditionally been based on several factors. Central among them is the attempt to serve

that restricted immigration from southern and eastern Europe, the Balkans, and Russia. This Act was passed partly on the belief that “the recent immigrants, as a whole, present a higher percentage of inborn socially inadequate qualities than do the older stock”); ELLEN CHELSER, *WOMAN OF VALOR: MARGARET SANGER AND THE BIRTH CONTROL MOVEMENT IN AMERICA* 313–35 (1992) (discussing how birth control was used as a means to weed out the unfit).

29. See generally RICHARD LYNN, *EUGENICS: A REASSESSMENT* 58 (2001) (noting various justifications for eugenics developed by others, including physical courage, beauty, and the like).

30. See generally *id.* at 95-96 (noting the general belief that if the intelligence level of the population could be increased, a number of desirable social outcomes would follow and a number of undesirable social phenomena would be reduced).

31. See *id.* at 16 (2003). See, e.g., ARIZ. REV. STAT. ANN. §§ 8-101 to 8-173 (2007); CAL. FAM. CODE §§ 7660–9300 (2004.).

32. Joan Heifetz Hollinger, *Adoption Law*, *FUTURE CHILD.*, Spring 1993, at 43, 43, http://www.futureofchildren.org/usr_doc/vol3no1ART3.PDF.

33. *Id.* at 43.

34. *Id.* at 44.

35. *Id.* at 43-44.

36. *Id.* at 44.

the child's best interests by finding suitable adoptive parents.³⁷ There is, however, no real test as to what "best interests" means, and it has been interpreted in a variety of ways.³⁸ While some people are straightforwardly categorized as ineligible to adopt children based on their criminal background, it is currently debatable whether factors such as marital status, sexual orientation, and ethnicity should affect whether a placement is made.³⁹

In many states, "courts, legislature, and child welfare agencies now acknowledge the unfairness of excluding people from consideration as adoptive parents solely on the basis of 'unconventional' characteristics pertaining to their marital or financial status, age, race, ethnicity, sexual orientation, or ability to bear children."⁴⁰ The passage of the Small Business Jobs Protection Act in 1996 prohibited adoption agencies from using race to delay or deny adoption placement.⁴¹ It is still unclear, however, whether adoption agencies can consider an adoptive parents' racial or cultural sensitivity in denying adoption.⁴²

Crucial to the controversy regarding the appropriateness of considering such factors as marital status, racial, or cultural sensitivity is the belief that placement of children based on

37. See *id.* at 48–49 (noting that the second element is "serving the child's interests by placement with suitable adoptive parents" and that most state adoption statutes require adherence to this element).

38. See *id.* at 48.

39. See *id.* at 48.

40. *Id.* at 48; see also Recent Case, *Family Law—Adoption—Massachusetts Allows Biological Mother and her Lesbian Partner Jointly to Adopt Child*, 107 HARV. L. REV. 751 (1994) [hereinafter *Massachusetts Allows*] (discussing *Adoption of Tammy*, in which adoption was sanctioned for a same-sex couple).

41. Recent Legislation, *Transracial Adoption—Congress Forbids Use of Race as a Factor in Adoptive Placement Decisions*, 110 HARV. L. REV. 1352, 1352 (1997) [hereinafter *Transracial Adoption*]. The relevant section of the Small Business Jobs Protection Act, 42 U.S.C. § 671(a)(18) (2000), states:

(18) . . . neither the State nor any other entity in the State that receives funds from the Federal Government and is involved in adoption or foster care placements may—

(A) deny to any person the opportunity to become an adoptive or a foster parent, on the basis of the race, color, or national origin of the person, or of the child, involved; or

(B) delay or deny the placement of a child for adoption or into foster care, on the basis of the race, color, or national origin of the adoptive or foster parent, or the child, involved.

42. *Transracial Adoption*, *supra* note 41, at 1352.

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such factors is in the best interests of children.⁴³ For example, the National Association of Black Social Workers has taken a position against transracial adoptions on the grounds that black children need to be raised by black parents in order to “develop a positive racial identity” and “to develop skills for coping with a racist society.”⁴⁴

It is evident, then, that while there is disagreement as to what limitations should be relevant in adoption placements, there is agreement that efforts should be taken to ensure the well being of the child.⁴⁵ Accordingly, restrictions on reproductive freedom, regarding who is eligible to adopt, are accepted in exchange for the positive long-term benefits of placing children in suitable homes.⁴⁶

43. See, e.g., Kim Forde-Mazrui, *Black Identity and Child Placement: The Best Interests of Black and Biracial Children* 92 MICH. L. REV. 925, 925–26 (1994).

44. The following passage details the organization’s thinking:

The National Association of Black Social Workers has taken a vehement stand against the placement of Black children in white homes for any reason. We affirm the inviolable position of Black children in Black families where they belong physically, psychologically and culturally in order that they receive the total sense of themselves and develop a sound projection of their future. . . .

. . . Black children in white homes are cut off from the healthy development of themselves as Black people, which development is the normal expectation and only true humanistic goal. Identity grows on the three levels of all human development; the physical, psychological and cultural and the nurturing of self identity is a prime function of the family. The incongruence of a white family performing this function for a Black child is easily recognized. The physical factor stands to maintain that child’s difference from his family. There is no chance of his resembling any relative. One’s physical identity with his own is of great significance. . . .

. . . In our society, the developmental needs of Black children are significantly different from those of white children. Black children are taught, from an early age, highly sophisticated coping techniques to deal with racist practices perpetrated by individuals and institutions. . . . Only a Black family can transmit the emotional and sensitive subtleties of perception and reaction essential for a Black child’s survival in a racist society. Our society is distinctly black or white and characterized by white racism at every level. We repudiate the fallacious and fantasied reasoning of some that whites adopting Black children will alter that basic character.

Id. at 926–27 (1994).

45. See *Massachusetts Allows*, *supra* note 40, at 751 (“The Massachusetts SJC has set an important precedent for homosexual rights. In looking to the ‘best interests of the child’”); Forde-Mazrui, *supra* note 43, at 929 (“When considering the placement of a child, the states generally charge courts with protecting the best interests of the child.”).

46. See Hollinger, *supra* note 32, at 44. For a background on adoption, see SPAR, *supra* note 1, at 159–93 (discussing the practice and politics of

C. Child Protective Services

In addition to restrictions on adoption placement, child protection laws illustrate that it is unacceptable for a parent to be engaged in child abuse or neglect.⁴⁷ Central to each of these limitations is the notion that these restrictions protect the interests of children by limiting who can be parents. Unlike eugenic ideology that supported forced sterilizations, child protective laws have largely been viewed as a justified limitation based on the need to protect a more vulnerable population.⁴⁸

Child protection laws that limit reproductive freedoms exist at the local, state, and federal levels.⁴⁹ The Child Abuse and Prevention Treatment Act, originally passed in 1974, aims to protect children from physical and sexual abuse.⁵⁰ In addition, federal law requires public child welfare agencies to take action when accounts of child abuse and neglect are reported.⁵¹ Child protection service workers are authorized, under certain circumstances, to seek court approval to remove the child from the home.⁵² This is, arguably, the most restrictive type of reproductive limitation, as it removes the child from the home and prevents reunification unless parent(s)

adoption).

47. See generally Child Abuse Prevention and Treatment Act, Pub. L. No. 93-247, 88 Stat. 4 (1974) (codified as amended in 42 U.S.C. §§ 5101-5106, 5116, 5118 (2000)).

48. See, e.g., G.A. Res. 1386 (XIV), U.N. Doc. A/RES/1386(XIV) (Nov. 20, 1959), available at <http://www.unhchr.ch/html/menu3/b/25.htm> (“[T]he child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection . . .”).

49. Janet E. Findlater and Susan Kelly, *Child Protective Services and Domestic Violence*, FUTURE CHILD., Winter 1999, at 85.

50. Kerwin Kaye, *Sexual Abuse Victims and the Wholesome Family: Feminist, Psychological, and State Discourses*, in REGULATING SEX: THE POLITICS OF INTIMACY AND IDENTITY 143, 143 (Elizabeth Bernstein and Laurie Schaffner eds., 2005). The Child Abuse Prevention and Treatment Act was rewritten and became the Child Abuse Prevention, Adoption and Family Services Act of 1988 (Pub. L. No. 100-294), which was later amended by the Child Abuse Prevention Challenge Grants Reauthorization Act of 1989 (Pub. L. No. 101-126) and the Drug Free School Amendments of 1989 (Pub. L. No. 101-226). See Admin. for Children & Families, U.S. Dep’t of Health & Human Serv., *Child Abuse Prevention and Treatment Act*, http://www.acf.hhs.gov/programs/cb/laws_policies/cblaws/capta/index.htm (last visited Oct. 11, 2008).

51. See Findlater & Kelly, *supra* note 49, at 85.

52. *Id.* at 86.

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satisfactorily complete a reunification plan.⁵³ These severe limitations are defended on the grounds that child abuse poses a severe risk of harm to children.⁵⁴ Studies have shown that there are negative developmental outcomes for children exposed to violence in the home.⁵⁵

D. Learning from These Experiences

These examples have shown that reproductive freedoms are not absolute, and that they exist in relationship to other concerns.⁵⁶ While the eugenics movement has largely been discredited, child protection and adoption laws remain mostly intact as means to ensure the protection of children. The advent of reproductive technologies has reopened the question concerning what is an appropriate restriction on reproductive freedoms, given that it is not uncommon for governments, or even private clinics, to limit who has access to infertility services.⁵⁷ The task, then, is to identify what is an appropriate restriction in this new realm of reproductive technologies.

Acceptable limitations are judged in part by looking closely at who is being protected and for what reasons.⁵⁸ During the eugenics movement, the forced sterilization of those considered “unfit” was a means to prevent the transmission of their unfit

53. See *id.* at 86; C.C. Carstens, *The Development of Social Work for Child Protection* 98 ANNALS OF THE AM. ACAD. OF POL. AND SOC. SCI. 135,19 (noting that the removal of children from the home is “[a] course [that] is so abhorrent to certain people who do not realize the menace that a brutal parent or an immoral home may provide both to the child and to the welfare of the community . . .”).

54. See *id.* at 138.

55. See generally John W. Fantuzzo & Wanda K. Mohr, *Prevalence and Effects of Child Exposure to Domestic Violence* FUTURE CHILD., Winter 1999, at 21, 27 (discussing the harms posed to children from domestic violence); see also Joy D. Osofsky, *The Impact of Violence on Children*, FUTURE CHILD., Winter 1999, at 33 (“Infants and toddlers who witness violence either in their homes or in their community show excessive irritability, immature behavior, sleep disturbances, emotional distress, fears of being alone, and regression in toileting and language.”).

56. See Petchesky, *supra* note 20, at 30 (discussing how “[i]ndividual women exercise, limit, or lose their capacity to bear children in relation to others to whom they are responsible and who are responsible for them—sexual partners, parents, children; and wider communities beyond the family”).

57. See discussion *infra* Part III.A.

58. See Petchesky, *supra* note 20, at 36 (“It would appear that the only way to distinguish justifiable from unjustifiable ‘protective’ laws and rules—that is, those that provide the necessary preconditions for moral and social autonomy from those that paternalistically deny such autonomy—is to look concretely at who is being protected and from what.”).

genes to later generations.⁵⁹ It was also based on the assumption that it was in their best interests—i.e., that they were incapable of handling reproductive responsibilities.⁶⁰ However, the assumptions required to posit such justifications have largely fallen into disrepute.⁶¹ Furthermore, to assume, in the absence of evidence, that there are categories of people who are incapable of being good parents is discriminatory. Thus, restricting reproductive freedoms in a manner similar to the eugenics movement is unwarranted and an alternative approach may be more desirable.⁶²

Child protection laws are aimed at protecting children from abuse and neglect, and are not based on a belief that certain categories of people should not be parents.⁶³ Rather, there is a recognition of the importance of family safety as well as the risk of harm to children exposed to family violence.⁶⁴ In such situations, child protection services work with the family to determine what services and support are needed in order to achieve a safe environment for the child.⁶⁵ In a similar fashion, adoption laws are focused on providing placements that are in

59. See Oswald, *supra* note 23, at 65 (arguing that eugenics has become more important in light of the advancements made regarding the role of heredity in physical and mental defects).

60. See Petchesky, *supra* note 20, at 35 (noting that opponents of regulations on sterilization argue that involuntary sterilization should be sanctioned for certain groups, “in the interests of caretakers, taxpayers, parents, future children, or the retarded themselves.” See generally Lynn, *supra* note 29).

61. See, e.g., *id.* at 38 (1979) (noting the lack of evidence illustrating that mildly retarded persons are incapable of raising children, and that there is little scientific basis for assuming a strict genetic determinism in most cases of mental disability Like all variations in intelligence, its sources represent a complex set of interactions between genetic and environmental determinants; the genetic determinants of intellectual abilities cannot be isolated, since these are themselves affected by environmental conditions.).

62. See *id.* at 38–39 (1979) (arguing that the “summary denial of the childbearing rights of retarded persons is discriminatory” and suggesting that “it would seem necessary to deal with the question of childbearing capacity in terms of an individual situation rather than on a wholesale basis . . .”).

63. See Findlater & Kelly, *supra* note 51, at 85.

64. See Osofsky, *supra* note 55, at 36 (noting that a literature review associates violence in the family with “adverse effects on children’s physical, cognitive, emotional, and social development”); *id.*, at 40 (stating that “[p]rotecting children and facilitating their development is a family’s most basic function”).

65. Findlater & Kelly, *supra* note 51, at 86.

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the best interests of the child.⁶⁶ It is important to note that with adoption laws, the categorical consideration of race in adoption placements is no longer plausible, but considerations of racial sensitivity are still permitted.⁶⁷ Thus, in deciding on the appropriate restrictions in the new realm of reproductive technologies, an approach more similar to child protection and adoption laws may be more beneficial. It is therefore important to consider who is being protected, and for what reasons.

III. THE MODERN ERA: REPRODUCTIVE TECHNOLOGIES AND REPRODUCTIVE FREEDOM

A. JURISDICTIONS THAT HAVE REGULATED

Almost three decades have passed since the first “test-tube” baby was born, and the use of assisted reproductive technologies has captured the attention of the larger community.⁶⁸ Popular media has often covered stories involving infertility services.⁶⁹ Given the increasing use of infertility services, it is not surprising that the concern over limiting reproductive freedom extends into the provision of infertility services. While the regulation of assisted reproductive technologies can exist in a variety of forms, this note focuses on limiting access to infertility services as an example of restricting reproductive freedom.

In the United Kingdom, the Human Fertilisation and Embryology Act 1990 (HFEA) regulates reproductive technologies.⁷⁰ This act does not specifically list requirements that must be met in order to access infertility services.⁷¹ Rather the HFEA Code of Practice takes a proscriptive approach by permitting access as long as the welfare of the

66. See *supra* Part II.B.

67. See *supra* text accompanying notes 41–44.

68. See BONNICKSEN, *supra* note 16, at 14–15 (reciting warnings, and other excited expressions about ART).

69. See, e.g., Kevin Sack, *Her Embryos or His?: A Divorcing Houston Couple Agree on All But the Fate of Three Frozen, Fertilized Eggs. It's a Legal Clash with Implications for Roe vs. Wade.*, L.A. TIMES, May 30, 2007, at A1.; Jane E. Allen, *Limiting Embryos: Doctors Report Fewer Multiple Births as a Result of In Vitro Fertilization, Although a Number of Patients Say They Want Twins—Or More.*, L.A. TIMES, Apr. 19, 2004, at F3.

70. Kerry Petersen, *The Regulation of Assisted Reproductive Technology: A Comparative Study of Permissive and Prescriptive Laws and Policies*, 9 J.L. & MED. 483, 489 (2002) (Austl.).

71. *Id.* at 489.

child to be born is considered.⁷² In practice, however, this does not mean that infertility clinics themselves do not take a more prescriptive approach when limiting access; there are clinics that deny access to lesbian women per se.⁷³

In Victoria, Australia, the Infertility Treatment Act 1995 currently regulates the realm of infertility services and research.⁷⁴ The legislation in Victoria is extremely prescriptive, and access is restricted by the eligibility requirements - of the Infertility Treatment Act 1995. More specifically, the marriage relationship clause/de facto heterosexual relationship clause and the infertility clause state:

7. Persons who may undergo treatment procedures

(1) A woman who undergoes a treatment procedure must

(a) be married and living with her husband on a genuine domestic basis; or

(b) be living with a man in a de facto relationship.⁷⁵

And:

(3) Before a woman undergoes a treatment procedure –

(a) a doctor must be satisfied, on reasonable grounds, from an examination or from treatment he or she has carried out that the woman is unlikely to become pregnant from an oocyte produced by her and sperm produced by her husband other than by a treatment procedure⁷⁶

Thus, there are two core requirements for access to infertility services (i.e. that the couple be in a married/de facto heterosexual relationship and clinical infertility).

In the United States, there is no national law that

72. *See id.* at 489–90.

73. *See id.* at 490.

74. Infertility Treatment (Amendment) Act 1997, No. 37 (Vict., Austl.), available at <http://www.legislation.vic.gov.au/> (follow “Victorian Statute Book” hyperlink; then follow “1997” hyperlink; then follow “Infertility Treatment (Amendment) Act 1997” hyperlink; then follow “97-037a.pdf (Acrobat - 149 Kilobytes)” hyperlink), at 485. The original legislation was called The Infertility (Medical Procedures) Act 1984.

75. *Id.* The amendment to the Infertility Treatment Act 1995 that expanded access to de facto couples occurred in 1997. *See* H W Gordon Baker, *Problems with the Regulation of Assisted Reproductive Technology: A Clinician’s Perspective*, 9 J.L. & MED. 457, 461 (2002) (Austl.).

76. Infertility Treatment Act 1995, No. 63 (Vict., Austl.), *microformed on* Acts of the Victorian Parliament 1995, pt. 2 (William S. Hein & Co., Inc.). S. 3(1) definition of “husband” inserted by No. 37/1996 s. 6(2): “husband”, in relation to a woman who is living with a man in a de facto relationship, means the man with whom she is living in that de facto relationship. *Id.*

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regulates the use of reproductive technologies.⁷⁷ In the absence of national (and state) regulation, private fertility clinics are free to restrict access in the manner they see fit. Given the nature of these technologies, it is appropriate to address whether these restrictions are appropriate, and if so, how they should be fashioned. While both Victoria and the United Kingdom have placed limitations on accessing infertility services, Victoria is unique in that it has chosen to enact strict requirements rather than guiding principles like in the United Kingdom.⁷⁸ In deciding what these restrictions should look like, it is beneficial to assess the experiences of a jurisdiction that has chosen a prescriptive approach.

B. THE VICTORIAN EXPERIENCE⁷⁹

Australia's first test-tube baby was born in Melbourne, Victoria in 1980. The Infertility (Medical Procedures) Act 1984 was passed shortly after, and Victoria became the first jurisdiction to pass legislation that regulated infertility services and research.⁸⁰ In 1995, the legislation was revised and became the Infertility Treatment Act 1995.

The question as to who should have access to infertility services is especially relevant in Victoria because access is currently restricted by the eligibility requirements of section 8 of the Infertility Treatment Act 1995.⁸¹ Victoria has regulated access to infertility services for over two decades, and several changes have been made to these requirements. Under the Infertility (Medical Procedures) Act 1984, one of the requirements for access to infertility services was marital

77. See SPAR *supra* note 1, at 5 (In the United States, however, regulatory and legislative authorities have largely ignored the market for reproductive services).

78. See *generally* Petersen, *supra* note 70 (comparing British and Victorian statutory regimes).

79. I spent a year in Victoria, Australia working with the Infertility Treatment Authority through the generous funding of the Australian-American Fulbright Commission. During this year, I had the opportunity to interview several persons involved in the legislation, in an attempt to better understand why and how Victoria chose legislation as a means to provide oversight to infertility services and research. To preserve anonymity, I will not be using any identifying details when making reference to materials obtained during interviews unless otherwise given permission.

80. See Helen Szoke & Jennifer Gunning, *Introduction*, in *THE REGULATION OF ASSISTED REPRODUCTIVE TECHNOLOGY 4* (Jennifer Gunning & Helen Szoke eds., 2003).

81. See *supra* p. 22.

status.⁸² De facto couples⁸³ were not allowed to access infertility services under the 1984 legislation or the revision that became the Infertility Treatment Act 1995.⁸⁴ In 1997, the Act was amended to allow de facto couples access to infertility services.⁸⁵ While access was expanded in 1997, there were still categories of people who were routinely denied access to infertility services. In particular, single women and same-sex couples are still largely excluded from access to infertility services. The following table depicts challenges to the access requirements of section 8(1) and 8(3a).⁸⁶

1996	Three unmarried/de facto couples take their case to the Human Rights and Equal Opportunity Commission (HREOC) after being denied access to IVF services by hospitals.
1997	The case is decided in their favor (hospitals had breached the Commonwealth Sex Discrimination Act by refusing to allow them access to infertility services). The Infertility Treatment Act 1995 is amended to extend access to de facto couples.
1998	A single woman is denied access to infertility services and takes her case to the HREOC claiming

82. Infertility (Medical Procedures) Treatment Act 1984, No. 10163 (Vict., Austl.), *microformed on* Acts of the Victorian Parliament 1984, pt. 2 (William S. Hein & Co., Inc.).

83. A de facto relationship “means the relationship of a man and a woman who are living together as husband and wife on a genuine domestic basis, although not married.” Infertility Treatment (Amendment) Act 1997, No. 37, pt. 2 § 6(2) (Vict., Austl.).

84. Infertility (Medical Procedures) Act 1984, No. 10163; Infertility Treatment Act 1995, No. 63.

85. See Baker, *supra* note 75, at 461.

86. See Szoke, *supra* note 3; Interview with John McBain (October 14, 2005), in Melbourne, Australia; Baker, *supra* note 75; Helen Szoke, *The Nanny State or Responsible Government?* 9 J.L. & MED. 470 (2002) (Austl.).

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	discrimination.
1999	The HREOC rules in favor of the single woman. Infertility Treatment Act 1995 is not amended to incorporate tribunal ruling.
2000	Dr. John McBain takes the above case to the Federal Court. The Federal Court rules that the marriage/de facto heterosexual relationship clause of the Infertility Treatment Act 1995 is inconsistent with the Commonwealth Sex Discrimination Act.
2000	Provision regarding marriage/de facto heterosexual relationship clause becomes inoperative but clinical infertility remains a requirement for access.

Given Victoria's experience in restricting access and the challenges that have been made to these restrictions, it is possible to observe the rationale behind these limitations. It thus becomes possible to discern which reasons are based on discrimination, as in the historical example of eugenics, and which are based on valid reasons, as in the current model of child protective services and adoption laws.

In September of 2008, the Victorian government introduced the Assisted Reproductive Treatment Bill 2008 to its Parliament.⁸⁷ This new bill will, among other things, "[e]nsure Victoria's laws are compatible with Federal discrimination laws by providing that women regardless of marital status or sexual orientation can gain access to assisted reproductive treatment."⁸⁸ While this bill is still before Parliament, its very existence exemplifies the growing recognition that new laws were needed to better protect the rights of parties seeking ART services, as well as the rights of

87. INFERTILITY TREATMENT AUTHORITY, ASSISTED REPRODUCTIVE TREATMENT BILL 2008 (2008), <http://www.ita.org.au/www/257/1001127/displayarticle/1001979.html>.

88. Press Release, Infertility Treatment Authority, Reforms to Protect Children and Provide Certainty (Sept. 9, 2008), <http://www.ita.org.au/secure/downloadfile.asp?fileid=1001975>.

the children to be born.⁸⁹

IV. LIMITING ACCESS TO ART: ON WHAT GROUNDS?

Traditional concepts of the nuclear family have changed drastically in the last few decades.⁹⁰ This trend, in combination with the advent of assisted reproductive technologies, has enabled single women and same-sex couples to pursue parenthood.⁹¹ Given that single women and same-sex couples have often been denied access to infertility services on principle, the question then becomes whether or not these restrictions are warranted.⁹²

By analyzing the Victorian experience in restricting access to infertility services, as well as the subsequent successful and unsuccessful attempts to amend the legislation to further expand access, it becomes possible to assess the rationale behind limiting access. More specifically, by comparing the process that resulted in an amendment expanding access to de facto couples with the process that did not result in an expansion of access to single women and same-sex couples, one can determine whether there is a fundamental difference between the two processes, or whether it is something else that has led to the different outcome.

A. CHALLENGES TO THE VICTORIAN ACCESS REQUIREMENTS

Under the original legislation, the Infertility (Medical Procedures) Act 1984 limited access to infertility services to married couples.⁹³ Prior to this legislation, the Waller committee published a report in September of 1982 which

89. *See id.*

90. *See e.g.*, Vern L. Bengtson, *Beyond the Nuclear Family: The Increasing Importance of Multigenerational Bonds*, 63 J. MARRIAGE AND FAMILY 1 (2001); Radhika Rao, *Assisted Reproductive Technology and the Threat to the Traditional Family*, 47 HASTINGS L.J. 951 (1995-96).

91. *See* JOHN ROBERTSON, *supra* note 21, at 13-14 (1994). *See also* Charlotte J. Patterson, *Lesbian and Gay Couples Considering Parenthood: An Agenda for Research, Service, and Advocacy*, 1 J. OF GAY AND LESBIAN SOCIAL SERVICES 33, 34 (1994); RUTH MCNAIR, OUTCOMES FOR CHILDREN BORN OF A.R.T. IN A DIVERSE RANGE OF FAMILIES 1-2 (Victorian Law Reform Commission) (2004).

92. *See* ROBERT BLANK & JANNA C. MERRICK, HUMAN REPRODUCTION, EMERGING TECHNOLOGIES, AND CONFLICTING RIGHTS 10 (1995) (considering the circumstances in which restrictions on parents or potential parents are justified).

93. *See* Infertility (Medical Procedures) Act 1984, No. 10163 (Vict., Austl.).

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recommended that “the IVF programme be limited to cases in which the gametes are obtained from husband and wife and the embryos are transferred into the uterus of the wife.”⁹⁴ In spite of this recommendation, during the 1984 Parliamentary debates, much argument ensued about whether de facto couples should be allowed access to IVF treatment. As expressed by the Hon. C.J. Hogg,

[i]f a couple is accepted into the programme, and withstands and comes through the battery of physical and psychological tests but those persons are not married and live in a bona fide domestic relationship, that should be it. They should be allowed into the programme and allowed to take the chance of having a successful course of treatment, just as a married couple would be able to.⁹⁵

This sentiment was widely expressed in the transcripts of the 1984 debates, both in the Legislative Council and the Legislative Assembly.⁹⁶ However, when the Infertility (Medical Procedures) Act 1984 was passed, only married couples were eligible for infertility services.⁹⁷

This concern was raised again in 1991 when the Standing Review and Advisory Committee on Infertility, the monitoring body established by the Infertility (Medical Procedures) Act 1984, proposed that the legislation be revisited. Just as in the debates prior to the passage of the Infertility (Medical Procedures) Act 1984, several Parliament members voiced their concerns that de facto couples should be granted access to infertility services. Take for example the following statements made during the debates that occurred prior to the passage of the Infertility Treatment Act 1995:

[I]t absolutely amazes me that in 1995 we do not have a change in the legislation. I refer to the exclusion of de facto couples from the IVF program—in itself almost certainly a breach of the commonwealth *Sex Discrimination Act* and a provision absolutely out of step with community values and attitudes today.⁹⁸

94. COMM. TO CONSIDER SOC., ETHICAL & LEGAL ISSUES ARISING FROM IN VITRO FERTILIZATION, CONSOLIDATED REPORTS OF THE VICTORIAN INQUIRY INTO IVF AND RELATED ISSUES 36 (2d reprint Aug. 1990).

95. Parliament of Victoria, Legislative Council 810 (October 23, 1984) (statement of C.J. Hogg).

96. The Legislative Council and the Legislative Assembly are the two chambers of the Parliament of Victoria, Australia.

97. Infertility (Medical Procedures) Act 1984, No. 10163, pt.1 §§ 10(3)(a), 11(3)(a) (Vict., Austl.).

98. *Infertility Treatment Bill*, Parliament of Victoria, Legislative Council 1291 (1995) (statement of C.J. Hogg), available at <http://tex.parliament.vic.gov.au/bin/texthtmlt?form=VicHansard.adv> (under “All Members” select “Hogg”; under “Year” select “1995”; under “Month” select

The opposition is very concerned about the limitation on de facto couples gaining access to IVF treatment. The bill limits access to married couples only, precluding de facto couples. The federal *Sex Discrimination Act* prohibits discrimination on the ground of marital status. The opposition believes the bill breaches the federal act. Because the commonwealth constitution provides that commonwealth legislation overrides inconsistent state legislation in the same area, the opposition believes the attempt to limit IVF treatment to married couples and to exclude de facto couples will not only breach the commonwealth legislation but be ineffective. . . . The opposition believes they should not be excluded because it is unfair and discriminatory.⁹⁹

While members of Parliament vocalized their opposition to passing the Infertility Treatment Act 1995 without expanding access to de facto couples, these efforts to include de facto couples were not victorious. The Infertility Treatment Act 1995 was passed without alteration to the provisions which restricted access to infertility services to married couples.¹⁰⁰

However, in 1996, three de facto couples challenged their exclusion from IVF services to the Commonwealth Human Rights and Equal Opportunity Commission (HREOC). The HREOC ruled that this exclusion conflicted with the Commonwealth Sex Discrimination Act.¹⁰¹ Hospitals in Victoria were thus placed in a predicament; the current Victorian law prevented hospitals from treating de facto couples, but by doing so they breached the Commonwealth legislation. The Victorian Parliament responded quickly to the HREOC's ruling and passed amendments to the Infertility Treatment Act 1995 in 1997 that extended access to de facto couples.¹⁰²

This successful change to the legislation occurred as a result of a variety of factors, key to which was the growing

"June"; under "Day" select "7"; check "Legislative Council Only"; click "Search" button; follow "INFERTILITY TREATMENT BILL" hyperlink on the Hansard Search Summary screen).

99. *Infertility Treatment Bill*, Parliament of Victoria, Legislative Assembly 1923 (1995) (statement by Rep. Thwaites), available at <http://tex.parliament.vic.gov.au/bin/texhtmlt?form=VicHansard.adv> (under "All Members" select "Thwaites"; under "Year" select "1995"; under "Month" select "May"; under "Day" select "30"; check "Legislative Assembly Only"; click "Search" button; follow "INFERTILITY TREATMENT BILL" hyperlink on the Hansard Search Summary screen).

100. This requirement is only one of several that must be met in order to be granted access to infertility services.

101. Baker, *supra* note 75, at 461.

102. See Petersen, *supra* note 70, at 492.

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recognition of de facto couples and the subsequent challenge that was made to the HREOC. As stated by Dr. Napthine during the 1997 debates, “I recognise, as I think the community recognises, that there are many stable de facto relationships in our society and that access to [infertility] treatment by people in those relationships is appropriate.”¹⁰³

While the amendment to expand access to de facto couples was passed less than two years after the HREOC challenge, a similar dispute to expand access to single women and same-sex couples has not resulted in a similar outcome. In 1999, the HREOC found that a hospital had violated the Commonwealth Sex Discrimination Act when it denied access to donor sperm to a single woman.¹⁰⁴ The HREOC ruled that single women were in fact being discriminated against by the marriage/de facto heterosexual relationship provision of the Infertility Treatment Act 1995.¹⁰⁵ However, unlike the legislative response that followed the 1997 HREOC ruling regarding discrimination and de facto couples, there were no immediate steps taken by the Victorian Parliament to further amend the Infertility Treatment Act 1995. Given the lack of response, in 2000, Dr. John McBain took this case to the Federal Court “seeking a declaration that the Victorian law was inoperative due to its inconsistency with the Sex Discrimination Act.”¹⁰⁶

In the McBain case, the Federal Court took the ruling of the HREOC tribunal a step further and gave it the force of law,

103. *Infertility Treatment (Amendment) Bill*, Parliament of Victoria, Legislative Assembly 1711 (May 23, 1997) (statement of Rep. Napthine), available at [http://tex.parliament.vic.gov.au/bin/texhtmlt?form=VicHansard.dumpall&db=hansard91&dodraft=0&house=ASSEMBLY&speech=18092&activity=Second+Reading&title=INFERTILITY+TREATMENT+\(AMENDMENT\)+BILL&date1=23&date2=May&date3=1997&query=true%0A%09and+\(+data+contains+%27NAPHTHINE%27+\)%0A%09and+\(+members+contains+%27NAPHTHINE%27+\)%0A%09and+\(+hdate.hdate_3+=+1997+\)%0A%09and+\(+hdate.hdate_2+contains+%27May%27+\)%0A%09and+\(+hdate.hdate_1+=+23+\)%0A%09and+\(+house+contains+%27ASSEMBLY%27+\)%0A](http://tex.parliament.vic.gov.au/bin/texhtmlt?form=VicHansard.dumpall&db=hansard91&dodraft=0&house=ASSEMBLY&speech=18092&activity=Second+Reading&title=INFERTILITY+TREATMENT+(AMENDMENT)+BILL&date1=23&date2=May&date3=1997&query=true%0A%09and+(+data+contains+%27NAPHTHINE%27+)%0A%09and+(+members+contains+%27NAPHTHINE%27+)%0A%09and+(+hdate.hdate_3+=+1997+)%0A%09and+(+hdate.hdate_2+contains+%27May%27+)%0A%09and+(+hdate.hdate_1+=+23+)%0A%09and+(+house+contains+%27ASSEMBLY%27+)%0A) [hereinafter *Infertility Treatment (Amendment) Bill*].

104. Leslie Cannold & Lynn Gillam, *A New Consultation Management Process for Managing Divergent Community Views: Lesbian and Single Women’s Access to Artificial Insemination and ARTs*, in *THE REGULATION OF ASSISTED REPRODUCTIVE TECHNOLOGY* 203, 212 (Jennifer Gunning & Helen Szoke eds., 2003).

105. See Petersen, *supra* note 70, at 492 n.73.

106. Women’s Health Victoria, *Fertility Access: The Victorian Situation*, http://www.whv.org.au/factsheets/fertility_access_vic.htm (last visited Oct. 16, 2008).

holding that the marriage and de facto heterosexual relationship requirement of the Victorian Infertility Treatment Act 1995 was inconsistent with the Commonwealth Sex Discrimination Act.¹⁰⁷ Despite this ruling, the Victorian government did not respond by passing a legislative amendment to further extend access. Instead, the Infertility Treatment Authority interpreted the ruling to mean that while the marriage and de facto heterosexual relationship provision was inoperative, the requirement for infertility still remained.¹⁰⁸ This meant that while infertile single women and lesbian couples could access infertility services, fertile single women and lesbian couples remained ineligible.

Practically, this ruling has done little to expand access to single women and same-sex couples, since the majority of them seek access to infertility services not because they are clinically infertile but because they are socially infertile.¹⁰⁹ And despite the passage of a significant amount of time, and the knowledge from the previous challenge that the Victorian Parliament is indeed capable of amending legislative eligibility requirements, access has yet to be extended equally to single women and lesbian couples. It is thus prudent to determine why a legislative amendment has not been passed in this instance, and whether this demonstrates a warranted differential legislative outcome.

When comparing the challenge to extend access to de facto couples with the challenge to extend access to single women and lesbian couples, it is important to note that there are many similarities between the two examples. Both parties claimed discrimination on the basis of the Sex Discrimination Act, both took their case to the HREOC, and both had rulings in their favor. The only difference in process is that in the second

107. *See* *McBain v. Victoria* (2000) F.C.R. 1009 http://www.austlii.edu.au/au/cases/cth/federal_ct/2000/1009.html. See also Petersen, *supra* note 70, at 492.

108. INFERTILITY TREATMENT AUTHORITY, ELIGIBILITY FOR DONOR TREATMENT (2006), <http://www.ita.org.au/www/257/1001127/displayarticle/1001214.html> (stating that “[t]he ITA’s understanding is that parliament’s intention in section 20 was to limit the use of donor gametes to instances where it is clinically necessary”).

109. John A. Robertson, *Gay and Lesbian Access to Assisted Reproductive Technology*, 55 CASE W. RES. L. REV. 323, 324–25 (2004) (“Homosexuals may also seek ARTs for infertility, but more often they use them because they cannot reproduce with their partners or others of the same sex.”).

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challenge there was a federal court ruling that favored expanding access. Given that a federal court ruling would intuitively seem to make an amendment more likely, something else must explain why single women and lesbian couples have been denied access to infertility services.

B. WHY DIFFERENT OUTCOMES? ARE THEY JUSTIFIED?

In examining the rationale behind the difference in outcome, two main themes emerge—the role of community acceptance in legislative amendments, and considerations as to the best interests and welfare of the child to be born.

1. The Role of Community Acceptance

In considering the first theme, many members of the Victorian community acknowledged that the level of societal acceptance of de facto couples versus that of single/lesbian women having access to IVF differed.¹¹⁰ Consider the following statements, each expressed by a member of the Victorian community:

Well I think that's what it is really because I think that particularly if society has changed, and we're now much more accepting of men and women that live together that aren't actually married. . . . [B]ut there are a lot of people in the community who are uncomfortable about gay relationships and about single women having children.¹¹¹

By 1997, in Victoria, unmarried heterosexual couples were basically treated, legally speaking, virtually identically to married couples. And that probably wasn't the case in 1984 when the original act was passed. Since the 1980s, throughout Australia, unmarried heterosexual couples are really the same as if you're married. So that's one reason. . . . But of course the other reason, it's just politically much more sensitive to extend the act to single women and lesbians whereas it was politically not very difficult to extend it to people who really looked like they're married.¹¹²

110. See *Infertility Treatment (Amendment) Bill*, *supra* note 98, at 1711 (“[T]he community recognises[] that there are many stable [heterosexual] de facto relationships in our society and that access to [infertility] treatment by people in those relationships is appropriate.”); see also JOYCE A. MARTIN ET AL., U.S. DEP’T. HEALTH & HUMAN SERV., BIRTHS: FINAL DATA FOR 2004 11 (2006) (stating that 35.8% of births in the United States in 2004 were out of wedlock), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr55/nvsr55_01.pdf; *Births out of wedlock “Pass 40%,”* BBC NEWS, Feb. 21, 2006, http://news.bbc.co.uk/2/hi/uk_news/4733330.stm.

111. Interview with anonymous source, in Melbourne, Vict. (Jan. 17, 2006).

112. Interview with anonymous source, in Melbourne, Vict. (Nov. 18, 2005).

In part I suspect there is a general reluctance to open up the act and there's no doubt, that there would still be a lot of debate in the community about the question of lesbian couples, less around single women I suspect, but lesbian couples. It waxes and wanes but once it's in front of the public, there's always a lot of noise about it.¹¹³

In reality, public attitudes with respect to single women and same-sex couples seeking access to IVF were significantly more hostile than attitudes toward married couples.¹¹⁴ The 1998 Same Sex Relationships and the Law report published by the Equal Opportunity Commission (EOC) gauged the level of community support that existed for lesbian access to IVF. According to a member of that commission, "there was general support within the community, within the Victorian community, to end discrimination on the basis of same-sex couples."¹¹⁵ However, this attitude did not extend to giving same-sex couples access to IVF. This report published the following statement with regard to that particular concern:

The issues of access to reproductive technology and adoption rights for people in same sex relationships were the most contentious of all the issues raised by the Commission's discussion paper. . . . After analysing the submissions, the Commission is of the opinion that further consideration and community consultation is necessary prior to any further reform in these areas.¹¹⁶

Given that legislation is, in part, designed to reflect community values, the difference in public acceptance between de facto couples accessing infertility services versus single women and same-sex couples accessing infertility services may explain the difference in outcome. However, even assuming that these differential attitudes explain this difference, is this rationale a valid justification for denying single women and same-sex couples access to infertility services?

In making this consideration, it is important to first acknowledge the relationship between the majority's perspective and the role of democracy. On the one hand, it can be argued that "you have to respect the democratic process and respect what the majority argues for."¹¹⁷ On the other hand, as

113. Interview with anonymous source, in Melbourne, Vict. (Nov. 23, 2005).

114. See generally, Gabor T. Kovacs et al., *Community Attitudes to Assisted Reproductive Technology: A 20-Year Trend*, 179 MED. J. OF AUSTL. 536, 536-38 (2003).

115. Interview with anonymous, in Melbourne, Vict. (Feb. 13, 2006).

116. EQUAL OPPORTUNITY COMM'N VICT., SAME SEX RELATIONSHIPS AND THE LAW 28-29 (1998).

117. Interview with Bill Muehlenberg, Nat'l Vice President, Austl. Family

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expressed by an associate law professor at Melbourne University, “[i]t may seem democratic to say a majority of people think you shouldn’t have kids so you can’t have kids, but majorities don’t always do what is right.”¹¹⁸ From a historical standpoint, there are several infamous examples in which majority opinions have not been proper.¹¹⁹ Thus, “it’s essential to our conception of democracy that there be certain fundamental values that are protected by politicians, by the laws, even against the fashions of the majority or the pressure groups or the media.”¹²⁰ Since the extent to which the majority view should be reflected in policy is debatable, it is inconclusive whether negative community opinions warrant the denial of single women and same-sex couples to infertility services.

While societal values should play a role in policy making, it is important to note that negative attitudes often occur with any new biotechnology.¹²¹ It is not uncommon for societal perceptions with regards to new technological advances to change over time. When artificial insemination gained public attention in the early 1900s, people referred to it as promoting “a race of illegitimate souls.”¹²² During the early 1970s when scientists were pursuing the possibility of IVF, a British magazine wrote a cover story analogizing IVF to the atomic bomb.¹²³ IVF was perceived as an “unethical medical experimentation on possible future human beings” and “inherently immoral” in the very beginning.¹²⁴ During 1995,

Ass’n, in Melbourne, Vict. (Oct. 25, 2005).

118. Interview with anonymous, in Melbourne, Vict. (Nov. 18, 2005).

119. American slavery is a notorious and commonly cited example.

120. Interview with Anthony Fisher, Bishop, Archdiocese of Sydney, in Sydney, N.S.W. (Nov. 17, 2005).

121. See ROBIN MARANTZ HENIG, *PANDORA’S BABY* 174 (2004):

Emerging technologies, especially those that mimic functions we take to be central to our definitions of life and death and of what makes us unique and emphatically human, often seem gruesome or barbaric in prospect, filled with technical impossibilities or ethical conundrums. Blood transfusion, organ transplantation, mechanical respirators, and artificial insemination—all were greeted with suspicion at first. And then, as soon as these procedures have been done a few times without the sky caving in, the objections tend to fade away.

122. *Id.* at 10.

123. *Id.* at 86 (noting that the *Nova* article inferred that IVF babies were “the biggest threat since the atom bomb”).

124. Bonnicksen, *supra* note 16, at 15 (quoting and citing Paul Ramsey, a professor of religion); see also SPAR, *supra* note 1, at 26 (“For many outside observers, however, [the birth of Louise Brown, the first IVF baby], was somewhere between a nightmare and unmitigated sin; it was emblematic of both technology’s gruesome advance and the abnormal intervention of

almost three decades since the birth of the first “test-tube” baby, an estimated 2.8 million women had used infertility services such as IVF to treat infertility.¹²⁵

In addition to changing sentiments regarding new technologies, concerns about new applications of technologies also change over time. Consider for example the following table, which depicts the attitudes of Australians over the past two decades as to whether married couples, single women, and lesbian women should have access to reproductive technologies.¹²⁶

Table 3.2: Should IVF be available to help infertile married couples?

	July 1982-January 1997	October 2000-November 2001
Aggregate % of approval	74.8%	85.6%

Table 3.3: Should single women with no male partner have access to donor sperm?

	1993	October 2000
% of approval	18%	38%

Table 3.4: Should lesbian women have access to donor sperm?

	1993	October 2000
% of approval	7%	31%

The acceptability of various applications of infertility services have increased over time. While the approval rate of using infertility services remains greater for married couples than for single and lesbian women, it must be noted that

humankind into nature’s realm.”).

125. Elizabeth Hervey Stephen & Anjani Chandra, *Use of Infertility Services in the United States: 1995*, 32 FAM. PLAN. PERSP. 132, 132 (2000) (noting that 42% of the 6.7 million women with fertility problems in 1995 received fertility services); see also HENIG, *supra* note 121, at 229–30 (“By 1983 ten years had passed During this single decade, this blink of an eye in objective time, a silent revolution had taken place in society’s view of children like Louise Brown, who by now was almost ready for kindergarten. Test tube babies had gone from being a risky and bizarre idea to being ordinary little everyday miracles . . .”).

126. Kovacs et al., *supra* note 114, at 536–38 (2003).

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infertility services have been available to married couples since 1987 while single and lesbian women still only have limited access to infertility services.

There is a history of objections and subsequent acceptance of the use of various biotechnologies. Thus, the lack of societal approval of same-sex couples and single women accessing infertility services should not warrant excluding these categories of persons from these types of services.

2. Looking to the Best Interests and Welfare of the Child to be Born

The history of limiting reproductive freedoms in the United States illustrates that reproductive freedoms exist in relationship to other concerns.¹²⁷ The question then becomes, is the exclusion of single women and same-sex couples more akin to the concerns that excused forced sterilization during the eugenics movement, or is this exclusion more similar to the apprehensions that justify current adoption and child protection laws? In answering this question, it becomes important to identify who is being protected, and for what reasons.

Part 1, § 5 of the Infertility Treatment Act 1995 states the Act's guiding principles. Central among these principles is that "the welfare and interests of any person born or to be born as a result of a treatment procedure are paramount."¹²⁸ This is similar to the impetus behind adoption and child protection laws; the focus is on the best interests and welfare of children. Several other jurisdictions restrict access to infertility services on the same grounds. While the Human Fertilisation and Embryology Act 1990 in the United Kingdom does not make

127. *See supra* Part II.

128. The section states:

5. Guiding principles

(1) It is Parliament's intention that the following principles be given effect in administering this Act, carrying out functions under this Act, and in the carrying out of activities regulated by this Act-

(a) the welfare and interests of any person born or to be born as a result of a treatment procedure are paramount;

(b) human life should be preserved and protected;

(c) the interests of the family should be considered;

(d) infertile couples should be assisted in fulfilling their desire to have children.

(2) These principles are listed in descending order of importance and must be applied in that order.

Infertility Treatment Act 1995, No. 63, pt. 1 § 5 (Vict., Austl.).

categorical exclusion from access to infertility services, it states that the welfare of the child must be considered when deciding which women shall be provided infertility services.¹²⁹ In addition, private fertility clinics in the United States have been known to engage in gatekeeping in an attempt to safeguard child safety and welfare.¹³⁰ The uniformity across these various examples suggests that the welfare and interests of the child are a valid justification for limiting access to infertility services.

However, this uniformity does not demonstrate that excluding single women and same-sex couples is actually in the best interests of the child. In order to determine whether this is the case, it is important to consider the factors that are relevant in determining what is in the best interests of the child, and whether one can categorically state that single women and same-sex couples do worse on these measures.

These deliberations go beyond merely protecting children from physical harm, but also inquiring as to what would promote the best interests of the child.¹³¹ The UN Declaration of the Rights of the Child provides further guidance, stating that children should have the opportunity to “develop physically, mentally, morally, spiritually and socially in a healthy and normal manner”¹³² In addition, other factors that should be considered are “commitment, age, medical histories, ability to meet the needs of child or children, any risk to the child, including that of inherited disorders, and the effect on any existing child of the family.”¹³³

In excluding same-sex couples and single women from access to infertility services, the assumption is that children do worse in these households and/or are harmed by being brought up by these parents.¹³⁴ In adoption and child custody cases,

129. Human Fertilisation and Embryology Act 1990 (c. 37). See Petersen, *supra* note 70, at 489.

130. See Richard F. Storrow, *The Bioethics of Prospective Parenthood: In Pursuit of the Proper Standard for Gatekeeping in Infertility Clinics*, 28 CARDOZO L. REV. 2283, 2299–3000 (2007) (discussing gatekeeping as a “prominent” feature of “clinical gatekeeping”).

131. See *Id.*

132. G.A. Res. 1386 (XIV), *supra* note 48.

133. Storrow, *supra* note 130, at 2307 (quoting IFFS Surveillance 2004, 81 FERTILITY & STERILITY S33 (2004)).

134. Robertson, *supra* note 109, at 331; See Marsha Garrison, *Law Making for Baby Making: An Interpretative Approach to the Determination of Legal*

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courts and state legislatures have been known to prefer heterosexual parents over homosexual parents.¹³⁵ In addition, a study conducted on gatekeeping practices of fertility clinics showed that being single or in a lesbian relationship were two potential grounds for denying services to candidates.¹³⁶ That is, these clinics would potentially deny access categorically on these grounds without independent inquiry as to whether these candidates would in fact harm the child to be born.

Despite these practices, and perceptions that children do worse when raised in single parent and lesbian parent households, there is a lack of evidence supporting this assertion.¹³⁷ Rather, the evidence points to the fact that single women and same-sex couples can be just as good parents as married/de facto couples.¹³⁸ For example, in *Adoption of Tammy*, which involved a same-sex couple, the judge found that adoption by the couple would be in the best interest of the child.¹³⁹ Studies have shown that children with lesbian parents develop similarly to children with heterosexual parents in regards to parent-child relationship, socio-emotional development, psychiatric ratings, and gender development.¹⁴⁰ Research also indicates that family processes and relationships (and not family structure) are responsible for how well a child does emotionally, socially, and psychologically.¹⁴¹ It is also important to note that women, whether single or in a same-sex relationship, who seek infertility services will have given parenthood much more deliberation than many people who

Parentage 113 HARV. L. REV. 835, 894 (2000) (stating that most Americans believe that children are better off in two-parent households).

135. Robertson, *supra* note 109, at 331.

136. Andrea D. Gurmankin et al., *Screening Practices and Beliefs of Assisted Reproductive Technology Programs*, 83 FERTILITY & STERILITY 61, 65 (2005).

137. *Id.* at 2306 (“[N]o data exists showing that special patient groups—gays, lesbians, single women, and those too aged to procreate naturally—are invariably poor parents . . .”); JACKSON, *supra* note 5, at 193.

138. See, e.g., Robertson, *supra* note 109, at 371 (“Given that gay and lesbian parents are equally capable of providing a caring and meaningful rearing environment as are other persons, there is no basis for claiming that offspring are harmed by being born to gay and lesbian parents”).

139. See *Massachusetts Allows*, *supra* note 40, at 751.

140. VICT. LAW REFORM COMM’N, ASSISTED REPRODUCTIVE TECHNOLOGY & ADOPTION: FINAL REPORT 32 (2007).

141. *Id.*; see JACKSON, *supra* note 5, at 193 (“The chief causes of problems experienced by children who grow up with a single mother are poverty, isolation, residential mobility and the family discord associated with parental separation.”).

become parents by accident.¹⁴²

Thus, the assumption that being raised by a single parent or by lesbian parents is contrary to the welfare and interests of the child is unsubstantiated. As such, it cannot be used as a justification to restrict the reproductive freedoms of single women and same-sex couples such that they are excluded from accessing infertility services.

C. INEQUALITY AND PUBLIC HEALTH CONCERNS

Two main themes emerge from the Victorian experience as reasons for justifying the exclusion of single women and same-sex couples from infertility services. However, both reasons are insufficient to justify such restrictions. The Victorian experience has also revealed two additional reasons why single women and same-sex couples should not be denied access to infertility services.

1. Categorical Discrimination

First, these exclusions categorically exclude single women and same-sex couples from access to infertility services and are discriminatory. It is not uncommon for fertility clinics to deny access to services based solely on the ground that the couple seeking the services is homosexual.¹⁴³ The existence of such categorical limitations on reproductive freedoms resembles the history and rationale of forced sterilizations during the eugenics movement.¹⁴⁴ Instead of a wholesale analysis of the individual situation and the factors relevant to childrearing, this exclusion accepts as true the unsubstantiated assumptions of the unfitness of single women and same-sex couples to be parents.¹⁴⁵ To misuse the welfare of the child and/or societal values as a means to discriminate and express a preference for nuclear families is arguably similar to the unwarranted assumptions that were used to sterilize undesirables during the

142. JACKSON, *supra* note 5, at 195.

143. Mary Crossley, *Dimensions of Equality in Regulating Assisted Reproductive Technologies* (Univ. of Pittsburgh Sch. of Law Working Paper Series, Paper No. 30, 2005), available at <http://law.bepress.com/pittlwps/papers/art30/>.

144. See Petchesky, *supra* note 20, at 38 (1979) (“[S]ummary denial of the childbearing rights of retarded persons is discriminatory.”).

145. See *id.* at 38-39 (1979) (“[I]t would seem necessary to deal with the question of childbearing capacity in terms of an individual situation rather than on a wholesale basis.”).

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eugenics movement.¹⁴⁶ As such, history should tell us that these exclusions are not only unwarranted, but discriminatory as well.¹⁴⁷

2. Public Health Risks

Second, single women and same-sex couples that are otherwise excluded from access to infertility services often use other means to get access, leading to public health risks to both the woman and the child to be born. In Victoria, women who are denied access to infertility services sometimes travel to places where they do have access or self-inseminate in order to become pregnant.¹⁴⁸ Victorian women are not alone in this, as other studies have shown that American women who are otherwise denied access based on their marital status or sexual orientation resort to self-insemination as well.¹⁴⁹

In self inseminating, these women no longer have access to the routine screening that is otherwise conducting when donor sperm is utilized. As such, these women are putting themselves at higher risk for health problems.¹⁵⁰ In the United States, federal regulation requires that donated sperm be kept for six months and screened for HIV and other sexually transmitted diseases.¹⁵¹ Such safeguards are important given the existence of at least a dozen international cases of women who were infected with HIV as a result of artificial

146. See *supra* Part II.A.

147. See, e.g., Storrow, *supra* note 130, at 2308 (“[B]lanket judgments about whole classes of persons who might wish to employ assisted reproduction or about specific types of assisted reproduction is not the direction family policy should take.”).

148. VICT. LAW REFORM COMM’N, *supra* note 140, at 26.

149. To elaborate:

Exclusionary practices based on marital status or sexual orientation have forced some women to conclude third-party arrangements with known or anonymous donors. It has been reported that at least 1,500 unmarried women a year in the United States are having children by means of [donor insemination] DI despite the difficulty of gaining access to mainstream DI services.

BLANK & MERRICK, *supra* note 92, at 106 (citation omitted); Also:

Due to discriminatory access to the medicalized system of sperm procurement, an unknown amount of AI occurs outside doctors offices with privately procured sperm and self-administration via turkey basters or syringes. It has become an important avenue to pregnancy and child rearing for women who lack a male partner and wish to reproduce.

Robertson, *supra* note 109, at 8.

150. See BLANK & MERRICK, *supra* note 92, at 106.

151. See SPAR, *supra* note 1, at 37; JACKSON, *supra* note 5, at 224.

insemination using donor sperm between 1981 and 1985.¹⁵² Women who self-inseminate assume unnecessary, higher risks for infection, not only with HIV but also with other sexually transmitted diseases.¹⁵³

In Victoria, women who undergo donor insemination in other settings are not guaranteed the safeguards that are otherwise provided for women who use infertility services in a clinical setting. For example, Victorian legislation requires the donor's identity to be registered.¹⁵⁴ Children born to women who inseminate outside Victoria may be unable to obtain information about their donor's identity. This is in contrast to women who are inseminated in a clinical setting within Victoria.¹⁵⁵ Victorian women are also provided with counseling and legal guidance as to what it means to use donor sperm to have a child.¹⁵⁶ Outside the Victorian clinical setting, these safeguards cannot be guaranteed. As a result, women who self inseminate or travel out of state for access may be at a higher risk for legal and psychosocial problems. Furthermore, because Section 7 of the *Infertility Treatment Act 1995* provides that only doctors are permitted to inseminate outside the clinical setting, some women who self inseminate are afraid to seek advice because they believe their actions are illegal.¹⁵⁷

152. Mary E. Guinan, *Sperm Banks Should be Regulated*, in REPRODUCTIVE TECHNOLOGIES 169, 169 (Bruno Leone et al. eds., 1996).

153. Compare Guinan, *supra* note 152, at 170-71 (arguing that women who self-inseminate are at higher health risks) with Garrison, *supra* note 134, at 908 (arguing that women who self-inseminate can make use of private services in order to screen donor sperm).

154. VICT. LAW REFORM COMM'N, *supra* note 140, at 75.

155. *Id.*

156. *Id.*

157. The relevant section states:

7. Donor Inseminations

(1) A person may only carry out artificial insemination of a woman using sperm from a man who is not the husband of the woman at a place other than a hospital or centre licensed under Part 8 for the carrying out of donor insemination if he or she-

(a) is a doctor who is approved under Part 8 to carry out donor insemination; and

(b) is satisfied that the requirements of Divisions 2, 3 and 4 and section 36 have been met.

Penalty: 480 penalty units or 4 years imprisonment or both.

Infertility Treatment Act 1995, No. 63, pt. 2 div. 1 § 7 (Vict., Austl.); see, e.g., VICT. LAW REFORM COMM'N, *supra* note 140, at 77 (reporting that some women who self-inseminate "fear seeking appropriate health or legal advice because they believe that self-insemination is illegal and subject to penalties").

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The negative effects of alternative methods of donor insemination and accessing infertility services outside Victoria impact not only the women, but the children to be born as well. Children born may lack access to identifying information about their donor, as other jurisdictions may not require this information to be registered. From a preventive health perspective, it may be important for donor conceived children to be aware of their genetic background. Most diseases result from the interaction of multiple genes and environmental factors and cannot be detected using available DNA technology.¹⁵⁸ Thus, family history is an important tool in disease prevention and early detection; family risk can help predict risk for many chronic diseases such as heart disease and breast cancer.¹⁵⁹ Given that one of the Act's guiding principles is that "the welfare and interests of any person born or to be born as a result of a treatment procedure are paramount,"¹⁶⁰ these exclusions have the opposite effect and end up harming children born as a result of these methods.

Excluding single women and same-sex couples from access to infertility services is not only discriminatory, but may have the effect of contradicting efforts to safeguard the interests of the children born using these technologies. The Victorian experience thus illustrates the undesirability of categorically excluding persons from infertility services based on sexual orientation or marital status.

V. CONCLUSION

In Victoria, clinical gatekeeping to infertility services is a statutory requirement. The legislation prescribes that the welfare and interests of the child to be born must be taken into account, and that persons must be clinically infertile to access infertility services. In the United States, in the absence of state and national regulation, clinical gatekeeping is performed by many fertility clinics with clinicians screening using similar concerns. Given the prevailing belief that the welfare and interests of the child are not served by being raised by single

158. NATIONAL OFFICE OF PUBLIC HEALTH GENOMICS, CENTERS FOR DISEASE CONTROL FAMILY HISTORY PUBLIC HEALTH INITIATIVE (2007), <http://www.cdc.gov/genomics/famhistory/famhist.htm>.

159. Alan E. Guttacher, Francis S. Collins, & Richard H. Carmona. *The Family History – More Important Than Ever*. 351 NEW ENG. J. MED. 2333 (2005).

160. Infertility Treatment Act 1995, No. 63, pt. 1 § 5(1)(a).

women and same-sex couples, these persons have often been categorically excluded from access to infertility services in both the United States and Victoria.

Adoption and child protective services have illustrated the acceptability of using the interests and welfare of the child as justifying limitations on reproductive freedoms. However, the experience of forced sterilization during the eugenics movement illustrates the necessity of careful inquiry when limiting these freedoms. Unlike the restrictions on reproductive freedoms in adoption and child protection services, the categorical denial of same-sex couples and single women from access to infertility services cannot be justified. The experiences of Victoria demonstrates that such exclusions cannot be defended on the grounds that it is merely a representation of societal values, or that they are in the best interests of the children to be born. The experiences of Victorian women who self-inseminate and travel interstate to access infertility services also exemplify the negative implications that may result from these exclusions.

Categorical exclusion based on marital status or sexual orientation, whether prescribed by legislation or by private fertility clinics, contends to be a limitation based on the interests and welfare of the child to be born. However, the unequal application of gatekeeping is not based on substantiated evidence that doing so furthers the interests of children, and may in fact harm the interests of children. As such, these categorical exclusions may purport to limit reproductive freedoms in a manner similar to adoption and child protection services, but in reality limit in a manner more similar to forced sterilizations. These exclusions do not categorically protect and prevent harm to future children, but rather, rely on stereotypes, misinformation, and discriminatory practices to deny reproductive freedoms to single women and same-sex couples. Any limitations to reproductive freedoms in the realm of infertility services should be based on relevant "parenting" factors, rather than unsubstantiated blanket judgments about the suitability of certain persons to be parents.